General

Guideline Title

Hormonal contraceptive eligibility for women at high risk of HIV: guidance statement.

Bibliographic Source(s)

World Health Organization (WHO). Hormonal contraceptive eligibility for women at high risk of HIV: guidance statement. Geneva (Switzerland): World Health Organization (WHO); 2017. 20 p. [18 references]

Guideline Status

This is the current release of the guideline.

This guideline meets NGC's 2013 (revised) inclusion criteria.

Recommendations

Major Recommendations

Question: Does the use of a particular method of hormonal contraception directly increase the risk of human immunodeficiency virus (HIV) acquisition in women?

Recommendations for Hormonal Contraceptive Use among Women at High Risk of HIV Infection

Women and couples at high risk of HIV infection continue to be eligible to use all forms of hormonal contraception. Informed decision-making is a key organizing principle and standard in a human rights-based approach to contraceptive information and services. A shared decision-making approach to contraceptive use should be taken with all individuals, but special attention should be paid to using this approach with vulnerable populations, such as women at high risk of acquiring HIV.

Women at high risk can use the following hormonal contraceptive methods without restriction (*Medical eligibility criteria for contraceptive use* [MEC] category 1*): combined oral contraceptive pills (COCs), combined injectable contraceptives (CICs), combined contraceptive patches and rings, progestogen-only pills (POPs), and levonorgestrel (LNG) and etonogestrel (ETG) implants.

Women at high risk of acquiring HIV can generally use progestogen-only injectables (norethisterone enanthate [NET-EN] and intramuscular [IM] or subcutaneous [SC] depot medroxyprogesterone acetate [DMPA]) (MEC category 2**), but there must be clear provision of information beforehand to enable informed decision-making. There continues to be evidence of a possible increased risk of acquiring HIV among progestogen-only injectable users. Uncertainty exists about whether reports of any possible increased risk are due to methodological issues with the evidence or a real biological effect. In many settings, unintended pregnancies and/or pregnancy-related morbidity and mortality are common, and progestogen-only injectables are among the few methods widely available. Women should not be denied the use of progestogen-only injectables because of concerns about the possible increased risk. Women considering progestogen-only injectables should, however, be advised

about this, about the uncertainty over a causal relationship, and about how to minimize their risk of acquiring HIV.

*MEC category 1 indicates medical conditions or personal characteristics for which there are no restrictions on the use of the contraceptive method in question.

**Conditions classified as MEC category 2 indicate that the advantages of using the contraceptive method generally outweigh the theoretical or proven risks; the contraceptive method can generally be used.

Clinical Algorithm(s)

None provided

Scope

Disease/Condition(s)

- Unintended pregnancy
- Human immunodeficiency virus (HIV) infection

Guideline Category

Prevention

Clinical Specialty

Family Practice

Infectious Diseases

Obstetrics and Gynecology

Preventive Medicine

Intended Users

Advanced Practice Nurses

Allied Health Personnel

Health Care Providers

Nurses

Physician Assistants

Physicians

Public Health Departments

Students

Guideline Objective(s)

To revise specific recommendations in the *Medical eligibility criteria for contraceptive use, Fifth edition*, where appropriate based upon findings from a 2016 systematic review addressing whether the use of hormonal contraception increases the risk of human immunodeficiency virus (HIV) acquisition among women at high risk of HIV infection

Target Population

Women of reproductive age at high risk of human immunodeficiency virus (HIV) infection (not HIV-infected at baseline)

Interventions and Practices Considered

1. Use of a specific hormonal contraceptive method
    - Combined oral contraceptive pills (COCs)
    - Combined injectable contraceptives (CICs)
    - Combined contraceptive patches and rings
    - Progestogen-only pills (POPs)
    - Levonorgestrel (LNG) and etonogestrel (ETG) implants
    - Progestogen-only injectables (norethisterone enanthate [NET-EN] and intramuscular [IM] or subcutaneous [SC] depot medroxyprogesterone acetate [DMPA])
2. Provision of information beforehand to enable informed decision-making

Major Outcomes Considered

Incident laboratory-confirmed human immunodeficiency virus (HIV)

Methodology

Methods Used to Collect/Select the Evidence

Hand-searches of Published Literature (Primary Sources)

Hand-searches of Published Literature (Secondary Sources)

Searches of Electronic Databases

Description of Methods Used to Collect/Select the Evidence

Existing World Health Organization (WHO) recommendations on the use of specific hormonal contraceptive methods for women at high risk of human immunodeficiency virus (HIV) were reviewed in accordance with procedures outlined by the WHO Guidelines Review Committee (GRC) and the Grading of Recommendations Assessment, Development and Evaluation (GRADE) approach to evidence review. An updated systematic review (see the "Availability of Companion Documents" field) of the epidemiological and pharmacological evidence was conducted to answer the following PICO (Population, Intervention, Comparator, Outcome) question: Does the use of a particular method of hormonal contraception directly increase the risk of HIV acquisition in women?

An Updated Systematic Review of Epidemiological Evidence on Hormonal Contraceptive Methods and HIV Acquisition in Women

Inclusion/Exclusion Criteria

The reviewers included published primary research reports on women who were HIV-negative at baseline in longitudinal studies (observational studies or randomized trials, or meta-analyses containing data not otherwise captured in the search strategy) that measured incident, laboratory-confirmed HIV infection among women who used a specific method of hormonal contraception (injectables, oral contraceptives, implants, patches, rings, or levonorgestrel intrauterine devices [LNG-IUDs]) compared with incident HIV infections among women using a nonhormonal contraceptive method (e.g., condoms, nonhormonal IUD, sterilization, withdrawal, etc.) or no contraceptive method (henceforth, 'hormonal contraceptive versus non-use of hormonal contraception' comparisons). Some studies compared hormonal contraceptive users against a heterogeneous group including other hormonal contraceptive users, non-hormonal method users, and nonusers of contraception. The reviewers identified and included such studies, but considered the composition of the comparison group when assessing study quality.

The reviewers also included studies comparing incident HIV infection among HIV-negative women using a specific method of hormonal

contraception against HIV-negative women using another specific method of hormonal contraception (henceforth, 'head-to-head' analyses) in which the comparison group did not contain non-hormonal method users or nonusers of contraception.

Studies that did not report a risk estimate for the relationship between hormonal contraceptive use and HIV acquisition, cross-sectional studies, studies assessing only emergency contraception, conference abstracts, or other unpublished reports were excluded.

Search Strategy

The reviewers retained all articles included in the previous systematic review, unless superseded by a new published analysis based upon the same data. They searched PubMed and EMBASE for articles published in any language between 15 January 2014 and 15 January 2016, inclusive (see Appendix B of the systematic review for search strategy). They hand-searched reference lists of included studies. One reviewer conducted the literature search and 3 other reviewers screened titles, abstracts, and full-text manuscripts to determine inclusion using Covidence software.

Values and Preferences in Contraceptive Decision Making: a Systematic Review

Additionally, a systematic review of the literature was performed for studies (qualitative or quantitative) on contraceptive users' and providers' values, preferences, views, and concerns regarding the contraceptive methods considered under the MEC guidelines (Kennedy C., Values and preferences in contraceptive decision making: a systematic review, unpublished data submitted for publication, 2017). Any studies published between January 2005 and October 2016, in any language were searched for in 10 databases.

Number of Source Documents

An Updated Systematic Review of Epidemiological Evidence on Hormonal Contraceptive Methods and HIV Acquisition in Women

Twenty-two studies were included in the previous review. For this review, 312 new references were screened, 14 full-text reports were assessed, and four were excluded: two did not report on the association of interest, and two meta-analyses contained published data already captured by the search strategy. Ten new reports were included; one superseded a previously included study. See Figure 1 in the systematic review document (see the "Availability of Companion Documents" field).

Values and Preferences in Contraceptive Decision Making: a Systematic Review

A total of 206 studies were identified that met inclusion criteria. No studies were identified that focused specifically on the issue of potential increased risk of HIV acquisition associated with specific hormonal contraceptive methods. However, key themes in women's preferences were identified.

Methods Used to Assess the Quality and Strength of the Evidence

Weighting According to a Rating Scheme (Scheme Given)

Rating Scheme for the Strength of the Evidence

Quality of Evidence in Grading of Recommendations Assessment, Development and Evaluation (GRADE)

High: The guideline development group is very confident that the true effect lies close to that of the estimate of the effect.

Moderate: The guideline development group is moderately confident in the effect estimate: the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different.

Low: Confidence in the effect estimate is limited: the true effect may be substantially different from the estimate of the true effect.

Very low: The guideline development group has very little confidence in the effect estimate: the true effect is likely to be substantially different from the estimate of the effect.

Methods Used to Analyze the Evidence

Meta-Analysis

Description of the Methods Used to Analyze the Evidence

Existing World Health Organization (WHO) recommendations on the use of specific hormonal contraceptive methods for women at high risk of human immunodeficiency virus (HIV) were reviewed in accordance with procedures outlined by the WHO Guidelines Review Committee (GRC) and the Grading of Recommendations Assessment, Development and Evaluation (GRADE) approach to evidence review. An updated systematic review (see the "Availability of Companion Documents" field) of the epidemiological and pharmacological evidence was conducted to answer the following PICO (Population, Intervention, Comparator, Outcome) question: Does the use of a particular method of hormonal contraception directly increase the risk of HIV acquisition in women?

Data Extraction and Quality Assessment

The reviewers applied a study quality assessment framework used in the 2014 systematic review, with slight modifications for clarity. Briefly, studies that did not include adjustment for condom use or which had unclear measurement of exposure to hormonal contraception (see Appendix C of the systematic review for a full explanation of the quality assessment criteria) were considered 'unlikely to inform the primary question'. For comprehensiveness all studies that met the inclusion criteria, regardless of quality, were included. However, the reviewers focused on studies with neither of the two quality concerns noted above; they considered these studies 'informative but with important limitations' (IBWILs) to acknowledge that all studies to date are vulnerable to residual or uncontrolled confounding. All authors participated in confirming the study quality assessment framework and in rating the quality of each study. The reviewers adapted previously used abstraction forms that were pilot tested by all coauthors. All coauthors abstracted data from each newly included study that was considered as IBWIL. Study investigators were contacted if clarifications were needed.

Graphical Summaries

Forest plots were created using Microsoft Excel 2013 (Microsoft, Redmond, Washington, USA) to summarize point estimates for a given contraceptive method (i.e. oral contraceptives, injectables [nonspecified, depot medroxyprogesterone acetate (DMPA), and norethisterone enanthate (NET-EN)], or implants]). The reviewers focused on graphics summarizing only studies considered IBWIL, but graphs depicting all studies regardless of quality are provided in Appendix D of the systematic review.

Most studies estimated hazards ratios using Cox proportional hazards models; some also included estimates from a marginal structural model (MSM). A few estimated only incidence rate ratios (IRRs) (see Tables 1 and 2 in the systematic review). For clarity of presentation, the reviewers displayed the IRR or Cox hazards ratio, unless the MSM model generated qualitatively different estimates, in which case both Cox and MSM estimates are shown.

As in 2014, the review authors requested disaggregated estimates from authors of new studies classified as IBWIL and which included women from South Africa (where use of both DMPA and NET-EN is common) but which did *not* report separate estimates for each. Disaggregated estimates have reduced statistical power but greater epidemiological and clinical value, given the potential for different biological effects by contraceptive type or formulation.

Meta-analysis

Given concerns specific to DMPA, the reviewers performed a statistical meta-analysis for the effect of DMPA versus non-use of hormonal contraception on human immunodeficiency virus (HIV) acquisition (studies that did not disaggregate injectables were not included). For maximum comparability, the most fully adjusted Cox hazards ratio estimates were included from each study, except one that reported an adjusted IRR (IRRs can be interpreted similarly to hazards ratios under certain conditions). The reviewers log-transformed reported adjusted point estimates and 95% confidence intervals (95% CIs) to calculate standard errors using a random effects model. They assessed statistical heterogeneity using the I^2 statistic. Analyses were performed using Stata (Version 13.1, College Station, Texas, USA).

Grading the Overall Quality of Evidence

The Guideline Development Group (GDG) considered the overall quality of the epidemiologic evidence, paying particular attention to the strength and consistency of the data, according to the GRADE approach to evidence review. Based on the GRADE process, observational studies start with a strength of evidence grade of "low". Factors that could lower the evidence grade were limitations in the evidence, inconsistency between studies, imprecision of estimates, indirectness of evidence, publication bias; factors that could increase the evidence grade included presence of a

dose-response relationship, large magnitude of observed associations, and adjustment for plausible confounders affecting observed associations. The GDG also considered the coherence of various bodies of evidence (for example, DMPA or NET-EN versus non-hormonal contraception or versus combined oral contraceptives [COCs], and DMPA versus NET-EN). In addition, the GDG considered the information presented on potential biological mechanisms, as well as providers' and users' values and preferences regarding contraceptive methods. To assist the GDG in systematically incorporating these factors into guidance, existing WHO guidelines on human rights and contraceptive services were followed.

Methods Used to Formulate the Recommendations

Expert Consensus (Consensus Development Conference)

Description of Methods Used to Formulate the Recommendations

This document was prepared according to the standards and requirements specified in the *World Health Organization (WHO) handbook for guideline development* (see the "Availability of Companion Documents" field). In summary, with due attention to human rights standards and principles, the process included determining critical questions and outcomes, retrieving evidence, assessing, synthesizing and grading evidence, presenting the evidence using a structured approach, and formulating the recommendations.

WHO convened a meeting of the Guideline Development Group (GDG) during 1–2 December 2016 to review new evidence on the risk of human immunodeficiency virus (HIV) acquisition with hormonal contraception and, where appropriate, revise specific recommendations in the *Medical eligibility criteria for contraceptive use*. The GDG included 19 participants from 12 countries, including experts in family planning and HIV, representatives from affected populations, clinicians, epidemiologists, researchers, programme managers, policy-makers, and guideline methodologists (see Annex 1 in the original guideline document).

Existing WHO recommendations on the use of specific hormonal contraceptive methods for women at high risk of HIV were reviewed in accordance with procedures outlined by the WHO Guidelines Review Committee (GRC) and the Grading the Recommendations Assessment, Development and Evaluation (GRADE) approach to evidence review. An updated systematic review of the epidemiological and pharmacological evidence was conducted to answer the following PICO (Patient, Intervention, Comparison, Outcome) question: Does the use of a particular method of hormonal contraception directly increase the risk of HIV acquisition in women?

GRADE evidence profiles were prepared to assess the quality of the summarized evidence and include the range of the estimates of effect for each outcome assessed (see Annex 3 of the original guideline document). The peer-reviewed systematic review, GRADE evidence profiles, and human rights principles and standards in contraceptive provision served as the basis for the GDG's deliberations during the meeting.

After the initial discussions among the entire GDG, a small group prepared a draft based on the preceding discussions of the entire group. The draft was considered and revised by the entire GDG to achieve consensus on the final recommendations. New recommendations for progestogen-only injectables were determined and those for other hormonal contraceptive methods were upheld for women at high risk of HIV. Eligibility recommendations for intrauterine devices (IUDs) (levonorgestrel [LNG] and copper IUDs) were not reviewed by the GDG: these recommendations remain unchanged and are available in the *Medical eligibility criteria for contraceptive use*. For each contraceptive method, the GDG considered the following factors in making their determination:

- Quality of the evidence (GRADE profile)
- Values and preferences of contraceptive users and health care providers
- Balance of benefits and harms
- Priority of the problem
- Equity and human rights
- Acceptability
- Feasibility

Rating Scheme for the Strength of the Recommendations

Strength of Recommendations

- Strong: Strong recommendations communicate the message that the guideline is based on the confidence that the desirable effects of adherence to the recommendation outweigh the undesirable consequences. Strong recommendations are uncommon because the balance between the benefits and harms of implementing a recommendation is rarely certain. In particular, guideline development groups need to be

cautious when considering making strong recommendations on the basis of evidence whose quality is low or very low.

- Conditional: Recommendations that are conditional or weak are made when a guideline development group is less certain about the balance between the benefits and harms or disadvantages of implementing a recommendation. Conditional recommendations generally include a description of the conditions under which the end-user should or should not implement the recommendation.

Interpretation of Strong and Conditional Recommendations for an Intervention

Audience	Strong Recommendation	Conditional Recommendation
Patients	Most individuals in this situation would want the recommended course of action; only a small proportion would not. Formal decision aids are not likely to be needed to help individuals make decisions consistent with their values and preferences.	Most individuals in this situation would want the suggested course of action, but many would not.
Clinicians	Most individuals should receive the intervention. Adherence to the recommendation could be used as a quality criterion or performance indicator.	Different choices will be appropriate for individual patients, who will require assistance in arriving at a management decision consistent with his or her values and preferences. Decision aids may be useful in helping individuals make decisions consistent with their values and preferences.
Policymakers	The recommendation can be adopted as policy in most situations.	Policy-making will require substantial debate and involvement of various stakeholders.

Cost Analysis

Owing to the focus on contraceptive safety, opportunity costs were not formally assessed during the formulation of the recommendations, since costs may vary widely throughout different regions.

Method of Guideline Validation

External Peer Review

Internal Peer Review

Description of Method of Guideline Validation

A draft version of this statement was sent to the external peer review group of experts who did not participate in the Guideline Development Group (GDG) meeting (see Annex 1 in the original guideline document). Comments received from these reviewers were addressed and incorporated into the guidance as appropriate by the World Health Organization (WHO) Secretariat. The final version of the document was approved by the WHO Guidelines Review Committee on 18 January 2017.

Evidence Supporting the Recommendations

Type of Evidence Supporting the Recommendations

The type of supporting evidence is not specifically stated for each recommendation.

The available evidence included randomized controlled trials, cohort studies, and a meta-analysis.

Benefits/Harms of Implementing the Guideline Recommendations

Potential Benefits

- The availability and effective use of contraceptive methods decreases overall pregnancy-related mortality and morbidity, improves infant and child health, and reduces mother-to-child transmission of human immunodeficiency virus (HIV).
- Contraception is a life-saving intervention, and progestogen-only injectables are highly effective, reversible methods that are widely used in areas where the risk of maternal mortality and morbidity are very high.
- Women have the right to informed decision-making. Women prefer to have choice in methods, full information regarding benefits versus harms, and to make a final decision in conjunction with their provider (shared decision-making). Offering women the choice of a range of methods is important from both a health and a rights perspective.
- HIV is a life-threatening illness and a major global epidemic. Unintended pregnancy is a very common problem globally, and the risks associated with it are highest where maternal mortality and severe morbidity are also common. Both are priorities for public health.

Potential Harms

- Uncertainty exists in scientific data regarding an association between progestogen-only injectables and a possible increased risk of human immunodeficiency virus (HIV) acquisition. This possible increased risk of HIV acquisition was outweighed for the Guideline Development Group (GDG) by the very real risk of maternal mortality and morbidity associated with unintended pregnancy. The GDG noted that for individual women, this risk-to-benefit ratio would be different, and it is essential that an informed decision-making approach be taken with women considering progestogen-only injectables, and all contraceptive methods.
- New information increases concerns about depot medroxyprogesterone acetate (DMPA) and HIV acquisition risk in women. If the association is causal, the magnitude of effect is likely hazard ratio 1.5 or less. Data for other hormonal contraceptive methods, including norethisterone enanthate, are largely reassuring.

Qualifying Statements

Qualifying Statements

Qualifying Statements

Limitations of the Systematic Review

Previous reviews have addressed key methodological considerations about this body of literature, including potential for confounding, frequency, and accuracy of variable measurement, considerations related to 'direct' and 'total' effects, potential for publication bias, and limitations of individual studies, such as failure of some studies to disaggregate by specific hormonal content or formulation (e.g., most studies assessing oral contraceptives failed to disaggregate estimates by combined oral contraceptives [COCs] or progestogen-only pills [POPs]). The study quality framework is necessarily subjective, and the Guideline Development Group encourages continued discussion on how best to evaluate study quality in this body of evidence.

Implementation of the Guideline

Description of Implementation Strategy

Plans for Dissemination

A comprehensive dissemination and evaluation plan has been developed to ensure that this information is accurately communicated with all affected stakeholders. Priority audiences for this technical statement include health care providers, including students, national family planning and human immunodeficiency virus (HIV) programmes, Member States, and implementing partners, including the United Nations (UN) agencies and global leaders in sexual and reproductive health. In addition to this technical statement, derivative communication products will be developed, especially for women and girls, who are the end-beneficiaries and partners in shared decision-making regarding contraception. The technical statement will be translated into a range of languages to reach all stakeholders.

The plan will include widespread dissemination through the World Health Organization (WHO) regional and country offices, WHO Member States, the Joint United Nations Programme on HIV/AIDS (UNAIDS), the UN agency cosponsors of the Special Programme of Research, Development and Research Training in Human Reproduction (HRP) within the WHO Department of Reproductive Health and Research (that is, United Nations Development Programme [UNDP], United Nations Population Fund [UNFPA], United Nations Children's Fund (UNICEF),

WHO and the World Bank), WHO collaborating centres, the Implementing Best Practices Initiative, professional organizations, governmental and nongovernmental partner organizations working in the area of sexual and reproductive health, and civil society groups engaged in sexual and reproductive health projects.

The WHO Secretariat will work closely with sexual and reproductive health focal points, as well as HIV focal points in the WHO regional offices to conduct a series of regional events, including webinars in 2017. Active engagement with professional societies, including medical and nursing education associations will be sought.

WHO is committed to working with Member States and partners to ensure that the updated guidance is fully and correctly implemented into national policies and programmes. An evaluation survey targeting ministries of health, WHO offices and partners, professional organizations and civil society will be sent out. The objectives of this survey will be to evaluate the extent and effectiveness of the dissemination, and the implementation of the recommendations into national policies, to identify barriers to effective implementation, and to determine research gaps in contraceptive eligibility criteria for women at high risk of HIV. Information from this survey will be incorporated into subsequent dissemination strategies and guidance updates.

WHO will initiate a review of the recommendations in this statement after four years. WHO will continue to monitor the body of evidence informing these recommendations and will convene additional consultations should new evidence necessitate.

Implications for Policies, Programmes and Providers

The WHO works with Member States both to generate evidence-based contraceptive policy and to translate it into action within countries. Several resources from WHO are available to assist countries in providing high-quality, rights-based contraceptive care. The recommendations made in the *Medical eligibility criteria for contraceptive use* (MEC) are complemented by the following guidance documents: 'Selected practice recommendations for contraceptive use', 'Ensuring human rights in the provision of contraceptive information and services' (both the guidance and the implementation guide), 'Decision-making tool for family planning clients and providers', 'Family planning: A global handbook for providers', and The Training Resource Package for Family Planning. All of these guidelines and tools are available online and have been widely translated into different languages.

In addition to the above resources, the Guideline Development Group underscored the importance of the following points when communicating this updated guidance.

What Does This Evidence Mean for Policy-makers, Programme Managers and Providers?

- Based on current evidence, family planning programmes delivering services to women at high risk of HIV infection can continue to offer all methods of contraception.
- Comprehensive contraceptive and HIV information and counselling services must be available equally to everyone voluntarily, and free of discrimination, coercion or violence.
- Continued efforts to integrate high-quality family planning and HIV services is an essential strategy to optimize reproductive health for all individuals.
- Hormonal contraception protects against unintended pregnancy, not HIV or other sexually transmitted infections (STIs). All individuals at high risk of HIV or other STI need ready access to prevention strategies, such as condoms and, where appropriate, pre-exposure prophylaxis.
- National programmes are encouraged to systematically introduce, adapt or adopt evidence-based family planning guidelines according to local contexts.
- National programmes are urged to expand on the range of available family planning/contraceptive method options so that women and girls have a wide of range of contraceptive choices.
- Contraceptive counselling is a core component for supporting informed choice and decision-making by clients. Health care providers need support to provide women with comprehensive, evidence-based information on the full range of available methods and the advantages and disadvantages associated with their use.

Implementation Tools

Foreign Language Translations

For information about availability, see the *Availability of Companion Documents* and *Patient Resources* fields below.

Institute of Medicine (IOM) National Healthcare Quality Report Categories

IOM Care Need

Staying Healthy

IOM Domain

Effectiveness

Patient-centeredness

Safety

Identifying Information and Availability

Bibliographic Source(s)

World Health Organization (WHO). Hormonal contraceptive eligibility for women at high risk of HIV: guidance statement. Geneva (Switzerland): World Health Organization (WHO); 2017. 20 p. [18 references]

Adaptation

Not applicable: The guideline was not adapted from another source.

Date Released

2017

Guideline Developer(s)

World Health Organization - International Agency

Source(s) of Funding

The development of this technical statement was financially supported by the National Institutes of Health (NIH) and the United States Agency for International Development (USAID).

Guideline Committee

Guideline Development Group

Composition of Group That Authored the Guideline

Guideline Development Group Members: Richard Adanu (University of Ghana, Ghana) [unable to attend]; Emily Bass (AVAC, United States of America [USA]); Sharon Cameron (University of Edinburgh, United Kingdom of Great Britain and Northern Ireland [United Kingdom]); Caroline

Phiri Chibawe (Ministry of Health, Zambia); Maria del Carmen Cravioto (National Institute of Nutrition, Salvador Zubiran, Mexico) [unable to attend]; Kathryn Curtis (United States Centers for Disease Control and Prevention [CDC], USA); Alison Edelman (Oregon Health Sciences University, USA); Joanne Erdman (Dalhousie University, Canada) [unable to attend]; Mohammed Eslami (Ministry of Health and Education, Islamic Republic of Iran); Anna Glasier (University of Edinburgh, United Kingdom); Andy Gray (University of KwaZulu-Natal, South Africa) [unable to attend]; Philip Hannaford (University of Aberdeen, United Kingdom); Nathanial Khaole (National Department of Health, South Africa – retired); Address Malata (University of Malawi, Malawi) [unable to attend]; Olav Meirik (Institute Chileno de Medicina Reproductiva, Chile); Chelsea Morroni (University of Botswana-University of Pennsylvania Partnership, Botswana); Progestine Muganyizi (Muhimbili University of Health and Allied Sciences, Tanzania) [unable to attend]; Lilian Mworeko (International Community of Women Living with HIV Eastern Africa, Uganda); Herbert Peterson (University of North Carolina, USA); Pashang Waiba (AAFNO Nepal-Women Wing, Nepal)

Financial Disclosures/Conflicts of Interest

Members of the Guideline Development Group (GDG) and members of an external peer review group (who did not participate in the GDG meeting) submitted declaration-of-interest forms to the World Health Organization (WHO) Secretariat. The WHO Secretariat and the GDG reviewed these and found no conflicts of interest sufficient to preclude anyone from participating in the deliberations or the development of recommendations. A summary of the declared interests was prepared (see Annex 2 in the original guideline document).

Guideline Status

This is the current release of the guideline.

This guideline meets NGC's 2013 (revised) inclusion criteria.

Guideline Availability

Available from the World Health Organization (WHO) Web site. Also available in French and Portuguese from the WHO Web site.

Availability of Companion Documents

The following are available:

- Polis CB, Curtis KM, Hannaford PC, Phillips SJ, Chipato T, Kiarie JN, Westreich DJ, Steyn PS. An updated systematic review of epidemiological evidence on hormonal contraceptive methods and HIV acquisition in women. AIDS. 2016 Nov 13;30(17):2665-2683. Available from the AIDS Journal Web site.
- WHO handbook for guideline development, 2nd edition. Geneva (Switzerland): World Health Organization (WHO); 2014. 179 p. Available from the WHO Web site.
- Medical eligibility for contraceptive use, fifth edition. Geneva (Switzerland): World Health Organization (WHO); 2015 Aug. 267 p. Available from the WHO Web site.
- Hormonal contraceptive eligibility for women at high risk of HIV. Geneva (Switzerland): World Health Organization (WHO); 2017 Feb. 1 p. Available from the WHO Web site.
- Medical eligibility criteria wheel for contraceptive use. Geneva (Switzerland): World Health Organization (WHO); 2015 Jun. 8 p. Available from the WHO Web site.

Patient Resources

None available

NGC Status

This NGC summary was completed by ECRI Institute on May 17, 2017. The information was verified by the guideline developer on June 2,

2017.

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